Association Internationale des FEMMES-MÉDECINS

Numéro : 6 Juin 1932

SOMMAIRE

EDITION DE « L'EXPANSION SCIENTIFIQUE FRANÇAISE »

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PAYS NOUVELLEMENT REPRÉSENTÉS A L'A. I. F. M.

ET

RAPPORTS DES SECRÉTAIRES NATIONALES CORRESPONDANTES

COUNTRIES NEWLY REPRESENTED IN THE M. W. I. A.

AND

NATIONAL CORRESPONDING SECRETARIES' REPORTS

FINLANDE

L'Association Internationale des Femmes-Médecins est heureuse d'enregistrer l'adhésion d'une nouvelle section nationale, celle des femmes-médecins de Finlande, qui vient de se créer.

Nous exprimons aux femmes-médecins finlandaises, en même temps que le plaisir que nous avons de les accueillir parmi nous, nos souhaits d'amicale bienvenue.

Nous sommes heureuses de publier ci-dessous un rapport sur l'activité des femmes-médecins de Finlande, que vient de nous envoyer la Secrétaire Nationale Correspondante, Mme le Dr Zaïda Eriksson.

FINLAND

The Medical Women's International Association is happy to register the affiliation of a new national section which has recently been formed, that of the medical women of Finland.

We wish to express to the Finnish medical women our pleasure at numbering them among us and also our sincere greetings of cordial welcome.

We are happy to publish below a report of the activity of medical women in Finland, which has just been sent to us by Dr Zaïda Eriksson, the National Corresponding Secretary.

MEDICAL WOMEN IN FINLAND

The first woman physician in Finland, Rozina Heikel, was licensed to practise in 1878. After that there were no medical women until the year 1896, when two women, Ina Rosqvist and

Karolina Eskelin, passed their medical examination at the University of Helsingfors and began active medical work as fully-qualified physicians. The latter, Karolina Eskelin, was the first one to obtain the degree of a doctor of medicine and surgery, a purely scientific degree, not necessary for permission to practise but given on the merits of a dissertation on a special medical subject.

Nowadays, in the beginning of 1932, there are 110 fully-qualified women doctors in our country, of whom 9 have obtained the above-mentioned degree of doctor of medicine and surgery. In the year 1930 a woman, Laimi Leidenius, was nominated professor of gynecology and obstetrics at the State University in Helsingfors. This was the first time the post was given to a woman.

The Finnish medical women specialising in various branches are as follows : 6 in internal medicine, I in surgery, 4 in ophthalmology, 7 in pediatrics and 6 in women's diseases and obstetrics. Il women are house physicians at State Asylums (for the insane), among them one is Chief-Physician. In the field of tuberculosis 14 women are working, 2 as leading doctors at tuberculosis hospitals. 10 medical women hold positions as district medical officers in the countryside. There are 3 women doctors in the employ of foreign missions, 1 in China and 2 in Africa. A great number of medical women have their own practice in different parts of the country, mostly in the towns.

As a rule the social and economic standing of women doctors is very good and they enjoy, generally speaking, the entire confidence of the people.

Since the year 1912 medical women have the same privileges as medical men with regard to practice as well as to the right to hold official positions. Before that time these rights were more or less dependent on permission from the authorities.

Dr Zaïda Eriksson.

CHINE

L'A. I. F. M. vient d'établir une nouvelle liaison avec la Chine par l'aimable intermédiaire de quelques femmes-médecins de ce pays.

Le Dr Ting, du Peiyang Women's Hospital à Tientsin, nous a communiqué un rapport sur les débuts et le développement de l'activité des femmes-médecins en Chine, que nous sommes heureuses de pouvoir publier ci-dessous.

CHINA

The M. W. I. A. has just established a new link with China through the gracious intermediary of some medical women of that country.

Dr Ting, of Peiyang Women's Hospital in Tientsin, has sent us a report on the origin and development of the activity of medical women in China which we are happy to publish below.

Women Physicians In China

Chinese medical books mention thirteen branches of medicine, but say nothing of Obstetrics. For centuries the latter was neglected to the extent that foetal and maternal deaths were considered as either natural and unfortunate events of life or punishments for sinful deeds committed by members of the family. Chinese history mentions women writers, poets, artists, musicians, and even warriors, but it does not record a single woman physician. Women masseuses, midwives, and nurses have served one-half of our population at the time of greatest need. Sepsis is unknown to Chinese Medicine. Missionaries were the first to awaken our people to unneccessary suffering brought on by ignorance and negligence. They were also the first to establish modern hospitals. Thirty years ago Chinese women patients would have died rather than have men doctors for obstetrical and gynecological care. Thus grew up a special need in mission hospitals for medical women missionaries who came to China to establish hospitals entirely for women and children. Realizing the scope of medical service, and the importance of trained Chinese women physicians, medical missionaries attempted to train medical assistants for hospital work, for then there were no medical schools for men or for women. Thirty years ago we could count China's women physicians on our fingers. Today in China we can find quite a number of women physicians in every large city. Their distinct service is recognized by society because of unusual opportunities. Our women physicians have distinguished themselves in certain branches of medicine such as Obstetrics, Gynecology and Pediatrics.

Among our pioneer women physicians are Drs Ida Kahn, Mary Stone, Ya Mei Kin, Kin Yen Hsu and Amy Wong, all five of whom have rendered valuable service to China. After Dr Kahn graduated from Michigan University thirty years ago, she returned to her native land and has given faithful service at her mission hospital at Nanchang. People know Dr Kahn because of her excellent training and splendid work. She possesses a scientific mind and is ever ready to study a case from a student's point of view. Dr Kahn is a specialist in internal medicine besides being well acquainted with the diseases of women and children. Dr Stone, a classmate of Dr Kahn, was at Danforth Hospital, Kiukiang, until she started her own independent work at Shanghai fifteen years ago. Today, her hospital, her educational, and her religious activities are centered in a prominent compound at West Shanghai. Dr Stone is a surgeon of national reputation and possesses a most charming

personality. Dr Ya Mei Kin, who graduated from the Women's Medical College of New York City thirty years ago, first started her work in Japan. She was introduced to Ex-President Yean Shik Kai, then governor of Chili province, by Ex-President Roosevelt. Dr Kin was appointed by Governor Yuan to start a hospital for women and children at Tientsin. It was named the Peiyang Woman's Hospital, as that was the only hospital for women in North China supported by the government. There she gave ten years of valuable service to China. She early saw the need of trained nurses and started a training school. Under her able leadership her hospital was put on a modern basis. Unfortunately her services were discontinued in 1914 for lack of funds. A year later, the hospital was reopened and because at that time Dr Kin was doing a special piece of work in food chemistry, Dr Kahn was asked to be the head of that hospital and was in turn succeeded by the late Dr Li Yuin Tsao. During the four years in which Dr Tsao gave her service to the hospital, she did a very valuable piece of work. By her professional dignity she succeeded in earning the respect of the gentry class of Tientsin. The writer has the privilege of being the fourth medical director of this Peiyang Women's Hospital. While looking over the old records the writer noticed that this hospital was the first in China which had a definite health program in connection with its curative work. We had pre-natal and post-natal work long before any other hospital in China. Dr Kin started School Hygiene in connection with a school for orphan children before even such a term was known in China. Besides her professional reputation Dr Kin is well known in China and abroad because of her social activities. Dr Kin Yien Hsu graduated from Women's Medical College at Philadelphia some thirty years ago. Since her return she has given thirty years of service to her hospital at Foochow. At present she shows the fortunate results of unusual opportunities in Tropical Medicine. Her work, which she has enjoyed, is being continued by her sister. Dr Amy Wong has had a most eventful career and has enjoyed a wide private practice. As a medical assistant to a missionary doctor she rendered fourteen years of service to the Woman's Department of Saint Luke's hospital at Shanghai. But she was not satisfied to be a medical assistant, for she was a woman of ambition and vision. She was already thirty-seven years old when she started as a freshman in her medical course at Toronto University. After her graduation she worked in a government hospital at Nanking for three years. With her savings of three years' hospital work she came to Shanghai to start her private work. For the last twenty years she has been the leading woman physician in that great metropolis and has enjoyed a fine reputation and a large private practice. All these women physicians have rendered invaluable service to our people because of their professional training and by

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faithful work have earned the confidence of the public. Not only have the demands of the time made them experts in the special lines of their profession but they have kept up with the progress of medicine through occasional visits abroad. It is indeed a challenge to our junior colleagues to maintain their high professional standard and fine reputation.

In addition to sending women doctors to China, and training Chinese women in America for service in their homeland, missionaries also started Medical Schools in our country. Although these schools made humble beginnings from the point of view of modern facilities they met a great need. The medical schools for women are three in number ; Soochow Medical College for Women, Peking Union Medical College for Women, and Hackett Medical College.

In those days it was impossible to have laboratory material for demonstrations, the only materials available were book teaching and bed-side observation. Nevertheless, these schools produced a number of students of national reputation. Among these are Dr Zok Kyons Chang, a graduate of Hackett Medical College, who later started the Shanghai Medical College in connection with the Shanghai City Hospital. The school has been closed owing to lack of funds, but her hospital is still an important institution in Shanghai. Dr Marion Yang, an early graduate of Peking Union Medical College for Women, is known to China because of her public health activities. She is now the director of the health center at Peking. Dr C. Y. Chu, a student of Soochow Medical College and a graduate of Peking Union Medical College for Women, has just finished her book, « The Care of Mothers », which she has presented to the Ministry of Health for publication and free distribution. This is the first book of its kind prepared by a medical woman. Many of these graduates realized the importance of further study abroad and have taken advantage of opportunities to strengthen an already enviable position in their work.

In the past most of the women physicians have gone into general practice with a special preparation for coping with the diseases of women and children. In recent years large cities are demanding specialists and medical schools are adding Chinese Professors. Thus many have gone into special lines of work. Some are now in public health activities, others are practising or teaching their special lines in Medical schools. Hackett Medical College now has a number of Chinese women professors. Soochow Medical College for Women has amalgamated with the Shanghai Union Medical College and has a faculty made up mostly of women professors. Peking Union Medical College for Women has united with the Shantung Christian University and the department of Medicine is co-educational as most larger medical colleges in China now are. The opportunities for medical service are better, for we have better colleges to prepare women for medical

study, better medical schools for professional training, and better hospitals for actual treatment of the sick. With all these advantages we younger professional women should endeavor to keep up the good example set by our seniors. In the virgin field of medicine in China we have unlimited opportunities. Some of our women have gone into research work, as is evidenced by the example of Dr C. C. Wong, who is devoting her life to research work in chemistry. The past has shown that our medical women were capable of reaching a high standard of professional training, of maintaining that standard, and of winning public confidence. Our pioneers have earned these by their skill, their devotion and their sacrifice.

The writer does not undertake to state in definite terms what the medical profession will hold for our women. She only wishes to show that our pioneers brought credit to their profession and that our colleagues are earnestly doing their share in different lines of the medical field. Their activities have been enumerated above. It is a challenge to our medical women students to-day not to be satisfied with only maintaining the professional standard already set up but to add honour and dignity to the ranks which they will soon join. Dr M. I. TING.

BELGIQUE

(Extrait d'une lettre adressée à la Secrétaire Générale).

Chère Madame,

Je n'ai pas de rapport détaillé sur les Femmes-Médecins Belges à vous transmettre, mais je ne voudrais pas que l'A. I. F. M. et vous-même puissiez en déduire qu'elles sont inactives.

Réfractaires, jusqu'ici du moins, à l'idée d'un groupement médical exclusivement féminin, les Femmes-Médecins Belges n'en sont pas moins, je vous prie chère Madame de le croire, des travailleuses professionnellement et socialement de plus en plus actives. Plusieurs d'entre elles s'occupent avec succès de recherches scientifiques pures, un grand nombre travaillent dans les hôpitaux et se dévouent aux Œuvres d'Assistance et aux œuvres sociales. Beaucoup sont médecins attachés aux différents Ministères ainsi qu'aux établissements d'enseignement.

D'autres, de plus en plus nombreuses, font de la clientèle et leur succès s'affirme. D'une façon générale, la Femme-Médecin, en Belgique, jouit d'une haute considération, et elle peut, sans entraves, s'y faire une situation matérielle et morale satisfaisante.

J'espère, chère Madame, que vous voudrez bien considérer la présente lettre comme le rapport de la Secrétaire Nationale Correspondante. Dr J. E. VANDERVELDE.

CANADA

Seventh Annual Meeting

The Seventh Annual Meeting of the Federation of Medical Women of Canada was held at the Jericho Golf and Country Club, Vancouver, B. C. on June 25, 1931. The President, Dr Isabel Day, presided and gave a short address on the aims of the Federation. After welcoming the guests from out of town and expressing the thanks of the Federation for the hospitality of the Business and Professional Women's Club, the Women's Canadian Club, the Georgian Club and the Jericho Golf and Country Club, the following resolutions were carried :

Resolutions

1° The Canadian Federation approves of the proposed addition of the words 'the council comprises the officers and representatives of each country'.

2° The Federation considers that it would be advisable to modify the rhythm of the meetings of the Medical Women's International Association as suggested.

3° That every effort be made to extend the Federation of Medica Women in Canada, and to increase its membership in order that the sending of a delegate, chosen on a basis of scientific and medical merit, may be possible.

The election of officers for the ensuing year then took place and resulted as follows :

Officiers for 1932

Président, Dr Gladys Boyd, Toronto, Ont.
Vice-Présidents Dr Mabel Patterson, Dartmouth, N. S.
— Dr Mabel L. Hanington, St. John, N. B.
— Dr A. C. Macrae, Prince Edward Island.
— Dr Maude E. S. Abbott, Montreal, Que.
— Dr E. Maud Robertson, Boisevin, Mau.
— Dr Houston, Yorkton, Sask.
— Dr Clara Christie, Alberta.
— Dr I. Kennedy, Vancouver, B. C.
Secretary, Dr Isabel Ayer, 194 Oakwood Ave., Toronto.
Treasurer, Dr Rosamond Leacock, 64 Summerhill Gardens, Toronto.
National Corresponding Secretary, Dr Helen Mac Murchy, Dept. of National Health, Elgin Bldg., Ottawa.

Obituary Note

Dr Julia Thomas, one of the pioneer medical women of Canada died in Toronto on Sunday, June 28 th, 1931. Dr Thomas was a

faithful and kind physician and was greatly respected and esteemed by all who knew her. The funeral was on June 30th, from her home in Toronto to her old home in Oshawa, where interment took place in the Union Cemetery. The pall-bearers were her six nephews and grandnephews.

Dr Helen Mac Murchy.

DENMARK

During the year 1931 two medical women had their theses accepted by the University of Copenhagen, Dr Oline Christensen writing about « The Patho-physiology of Gastric Pains », Dr Elisabeth Svensgaard about « Blood Sugar in normal and sick children with special reference to Coeliac Diseases ».

In January 1932 Johanne Christiansen, M. D., who started the Convalescent Home « Casa Azzura », Maderno, Lago di Garda, passed the examination which gives « jus practicandi » in Italy and has now consulting hours twice a week at Milano, besides directing her Convalescent Home at Maderno.

The previously mentioned Female Students Hostel « Kvinderegensen » was ready for receiving students the Ist of February 1932 ; I have asked one of the young medical students to tell us about it : « Kvinderegensen » is a fine three-winged building on Amager Boulevard with a wonderful outlook over the harbour and Christianshavn with the beautiful spire of Our Saviour's Church. The building has three floors and basement. In the basement are the porter's rooms, gymnasium, ironing room and washing cellar. Furthermore the porter's wife has a little shop, where one can buy bread, eggs, milk and the like. On the ground floor there is amongst other things the vice- « ephor's » residence. The first floor is taken up by the bed-rooms, a drawing-room and a library, where the daily papers are to be found. The single rooms bear the names of the giver, who can be either a single person, or a town or a school.

On every floor there are two kitchens and two bath-rooms which are shared by 16 students. In the kitchens each has her own cupboard, also there are household articles of every kind such as pots, cups, plates and the like. The washing up is done by the women who also keep the rooms clean.

The rooms are large and light, nearly all facing south. Most of them have a little ante-room with a washing basin, a cupboard in the wall and a big built-in wardrobe, which goes from floor to ceiling. The furniture consists of a big writing-desk, a book case, moveable shelves, a writing-chair and an easy-chair and a bed under which there is a drawer for the bed-clothes, so that in the day-time it can be used as a divan.

Officially the Hostel is represented by 7 honorary « Ephors », Eli Moller, M. D. being the head of them. Our Queen is the « Protectress ».

To look after their interests the collegians have elected a committee, consisting of a chairman, a treasurer, a sportsman (who attends to the gymnastics, tennis-court and the like), a journalist and a secretary. Furthermore there is a « theater-man » who procures cheap theatre tickets. For newspapers and telephone each pays Kr. 1.50 per month.

The price for the rooms in the Hostel is Kr. 300 per annum, which is paid in 10 months at the rate of Kr. 30 per month. To some of the rooms are attached endowments but as yet there are only few, so that one cannot count on getting a free place.

The first condition of reception is of course that one studies at the University. As one must expect that there will be a rush for the available rooms, the result of the examinations will play a great role, but pecuniary matters do not count so much. There is room for 56 students but as most of the present ones are fairly young there will not be many available places the first two years.

In February 1932 Eli Moller, M. D. started sex education at the University, lecturing to female students.

The Committee dealing with the question about a book on sex-education — mentioned a year ago, came to the conclusion that a pamphlet here in Denmark would be of doubtful value as long as we did not have any books dealing with the subject in a thorough way and the members of the committee thought the book written by the two Swedish doctors, Alma Sundquist and Julia von Sneidern, the right book for the purpose. This book « Handlening i sexuell undervisning och uppforstran » has therefore been translated into Danish by Dr Gerda From Jorgensen, Dr A. Petersen, instructor at a training college, Mrs Johanne Steenberg and myself, the specialist forVenereal Diseases, Dr A. D. Petersen translating the part about venereal diseases and writing herself about Danish Legislation and the history of Danish Prostitution. The book came out in March 1932. It is already used as a text-book in Dr Eli Moller's lectures at the University and Dr Marie Krogh's lectures at the State Teachers College, which is a post graduate college open to teachers from the whole country. The teachers can attend at this college long or short courses, for which scholarships are given.

Dr Agnete Heise.

FRANCE

Mai 1931 — *Mai* 1932

Un fait important dans l'histoire de l'Association Française des Femmes-Médecins a été sa « reconnaissance d'utilité publique » par décret du 8 avril 1931. Cet acte lui confère une personnalité légale pleine et entière.

Comme chaque année l'A. F. F. M. a tenu des réunions mensuelles, les unes simples réunions amicales, les autres séances de travail où sont exposés et discutés des rapports portant principalement sur des questions d'hygiène sociale.

Aux séances de travail ont été étudiés :

L'œuvre poursuivie par le *Parti Social de la Santé Publique* qui a pour but principal de défendre et de protéger l'élément primordial de richesse et de prospérité qu'est la santé publique.

L'Œuvre de l'Approvisionnement des Prisons créée par Mme le Dr Stricker Rouvé dans le but de faire parvenir aux infirmières des prisons les échantillons médicamenteux reçus par les médecins afin qu'ils soient utilisés pour le soulagement des détenus.

Le *Rôle des Femmes-Médecins dans les Colonies Françaises.*

Les Modalités d'application des divers procédés d'*anesthésie pour accouchements normaux dans les services hospitaliers* d'après une enquête faite dans différents pays étrangers.

Les buts poursuivis par les deux ligues de *Réforme Sexuelle et d'Etudes Sexologiques* récemment fondées en France.

Le rapport présenté à la Chambre des Députés par le Dr Legros sur le *projet de révision de la loi de* 1902 *sur la Santé Publique.*

Les services spécialisés dans les hôpitaux de Paris pour le *traitement du rhumatisme chronique considéré comme maladie sociale.*

Un dîner a comme chaque année réuni de nombreuses femmes-médecins de Paris et de province.

Dr Germaine MONTREUIL-STRAUS.

HONGRIE

L'Association Hongroise des Femmes-Médecins a tenu en 1930 et en 1931 une Assemblée Générale et quatre réunions pour les besoins administratifs.

Nous avons eu plusieurs conférences très intéressantes faites par Mr le Professeur Elemer Scipiades, professeur de Gynécologie à Pecs, par Madame Charles Stumpf, vice présidente de l'Association Catholique des femmes, par Mme Aladar Magyary-Kossa qui nous a entretenues de la Croix Rouge de la Jeunesse.

Des causeries médico-sociales furent faites par : le Dr Andor Matyusovsky, membre du Ministère d'Hygiène Sociale, par Mme Dr Marguerite Ungar, avocate, par Mmes les Drs Piroska,

Elise Madarasz-Gemesy, Armand Melha, Maria Medi-Kiss, Marguerite Halasz, et Jeanne Kontrasty.

La vie sociale de notre Association fut particulièrement active durant cette année où nous avions la préoccupation et la joie d'organiser la grande réunion des femmes-médecins venant de toutes les parties du monde. Afin d'augmenter nos ressources financières en vue de l'organisation du Congrès, un concert fut organisé pour lequel les plus grands artistes apportèrent gracieusement leur concours : Mr le Dr Eugen Kerntner, professeur à l'Académie Liszt, Mme Maria Basilides de l'Opéra de Budapest, Mlle Ilona Pal, Dr Marguerite Halasz, Pr Paul Gyori et Mr Béla Esillery.

La réussite de ce concert fut complète et nous avons pu commencer les préparatifs du Congrès sans soucis pécuniaires.

L'Association Nationale des Femmes-Médecins Hongroises a pris part au Congrès de Vienne et a reçu avec le plus grand plaisir à Budapest la Présidente, les Vice-Présidentes et les Membres de l'Association Internationale des Femmes-Médecins et elle espère que les Femmes-médecins présentes ont emporté un bon souvenir de leur visite en Hongrie, c'est le souhait le plus cher à l'Association Hongroise.

Dr Vegess-Rege.

INDIA

The Association has now attained the age of 25 years, and has just held a very successful series of meetings at Bombay to celebrate the occasion. Perhaps the most popular function was the Association dinner, when 56 medical women were present, and a presentation was made to Dr A. C. Scott on her retirement from the post of Chief Medical Officer to the Women's Medical Service. There were interesting papers on gynaecological, obstetric and other subjects read and dicussed, and a lantern lecture was given in French by Mme le Dr Noêl on Aesthetic Surgery. Some of the members made a very enjoyable expedition across the Bombay Harbour to see the ancient Hindu rock-temples on the island of Elephanta.

During the last few months the Association has raised a fund of about Rs. 500. for a memorial to Dame Mary Scharlieb in the Hospital for Women founded by her at Madras. The Memorial is to take the form of a portrait, and a prize for Gynaecology and Obstetrics.

The General Medical Council for India mentioned in last years' report, is a further step nearer establishment. Its constitution is still the subject of much discussion, both in and outside the legislatures ; and our Association of Medical Women has also taken a keen interest in the matter and made various representations.

Another matter that is of great interest at the moment is the different proposals for the new constitution for this country. Various Indian members of our Association have taken a leading part in giving evidence before the Franchise Commission regarding the position of women under the proposed new constitution.

The quarterly issues of our Journal have appeared regularly ; various hand-books on subjects connected with Maternity and Child-Welfare have also been issued by some of our members, among which is a « Manual of Mothercraft » written by Dr Balfour for the Indian Red Cross and St. John Ambulance Association.

I would also mention, in original research, the work of Dr Talpade on « Diet in Bombay » which was published in the Indian Journal of Medical Research in October 1931.

Dr CURJEL-WILSON.

SWEDEN

1929-1930

The Swedish Association of Medical Women held two meetings in 1929. At the first on February 7th in Stockholm, Dr Ada Nilsson gave a report on the proposed legislation concerning a maternity-benefit. Discussion followed. Miss Hesselgren, Chairman of the Committee that was working out the bill, was present. Dr Sundquist told about the Paris Conference and outlined the Swedish report on « Sex Instruction ».

At the second meeting, on November 11th in Gothenburg, Dr Sundquist was elected chairman to succeed Dr Widerstrom who had resigned. A preliminary discussion on « Protective Legislation » took place. Some Norwegian and Danish women doctors were present as guests and it was suggested that the women doctors from the Scandinavian Countries should, if possible, make a joint stand against restrictive legislation for women at the Vienna Conference.

The Association held two meetings in 1930 ; at the first on April 13th in Stockholm it was decided to announce a competition for a booklet on « Sex Education in Childhood ». Dr Soderlund gave a lecture on « Doctors and Cosmetic Problems ».

At the second meeting on September 28th in Vanersborg, the members were the guests of Dr von Sneidern who, in her country home, provided a charming and unusual background for a meeting. Dr Ada Nilsson was elected chairman during the absence of Dr Sundquist and Dr Svedberg was elected corresponding secretary. Dr Nilsson gave a report on the result of the above mentioned competition. Of 8 papers sent in, the appointed committee had approved of 3. Two of these were found to be written by members of the Association (Dr Kjellberg and Dr Grubb). It was decided

to publish these three papers as separate booklets and have them on sale together. Dr Nilsson also gave a lecture on the problem of criminal abortion with special relation to conditions in Sweden.

The meetings have been attended by 20 to 30 members.

The average membership of the group during these years has been 65. The number of women doctors in Sweden is at present 144 or about 6 % of the medical profession in the country.

Dr Andrea SVEDBERG.

TCHÉCO-SLOVAQUIE

Avant mon départ de Londres en 1925, à l'occasion de ma dernière conversation avec Lady Barrett, qui était alors Présidente de l'Association Internationale des Femmes-Médecins, celle-ci me demanda à nouveau avec insistance de me charger d'organiser une association des femmes-médecins de la République Tchécoslovaque. Elle me promit de soutenir mes efforts de toutes ses forces. Lady Barrett et son mari ont toujours témoigné un vif intérêt à l'égard de mon pays dont ils connaissent l'histoire et avaient foi dans l'avenir de notre jeune État. On comprend facilement que Lady Barrett ait voulu gagner à la cause de l'Association Internationale des Femmes-Médecins ce pays qui compte un grand nombre de femmes-médecins et dont la culture intellectuelle est si avancée. Elle pensait que les femmes-médecins de chez nous n'étaient pas suffisament intéressées dans ce mouvement et disait que la Tchécoslovaquie était un des rares pays cultivés ne faisant pas partie de l'Association. Ce n'est que lorsque j'ai essayé d'amener nos femmes-médecins à former une association que j'ai connu la raison de ce qui paraissait être un manque d'intérêt : nos femmes-médecins étaient non seulement enrôlées dans des associations professionnelles mais encore dans une association féministe la « Fédération des Femmes Diplômées des Universités » et c'est pourquoi elles ne voyaient pas la nécessité de former une nouvelle association.

Ce n'est qu'en 1930, grâce à l'impulsion donnée par Mme le Dr Thuillier-Landry, Présidente de l'Association Internationale des Femmes-Médecins, et après une invitation pressante de l'A. I. F. M. que nos femmes-médecins se décidèrent à former l'Association des Femmes-Médecins de Tchécoslovaquie dont Mme le Dr Anna Honzakova fut élue Présidente. Notre association ne comptait au début que 24 membres, actuellement nous sommes 120 grâce à la convention établie par Mme le Dr Zuckermannova-Zichova, notre Présidente actuelle, et la Fédération des Femmes diplômées des Universités.

Je souhaite que d'ici quelque temps toutes les femmes-médecins de Tchécoslovaquie s'unissent pour collaborer utilement à l'Association Internationale des Femmes-Médecins en suivant et

en respectant les idées fondatrices de cette association et en oubliant les différences de nationalité, de religion et de politique.

Les femmes-médecins tchécoslovaques exercent presque toutes leur profession ; on les trouve dans les hôpitaux, dans les Caisses d'Assurances contre la maladie, au Ministère de l'Hygiène Publique et de la Culture Physique, dans les Administrations et même à l'Institut d'Hygiène de l'État. Quelques-unes sont Assistantes dans les Universités et une d'elles a été admise en qualité de Professeur Agrégé à l'Université de Bratislava. En théorie nos lois garantissent aux femmes les mêmes droits qu'aux hommes mais bien que le pourcentage de femmes-médecins soit de 10 %, jusqu'ici un seul siège de professeur a été octroyé à une femme-médecin.

Il résulte de tout ceci que notre Association des Femmes-Médecins de Tchécoslovaquie a beaucoup à faire pour le bien de nos femmes-médecins et que l'avenir plus encore que le présent démontrera l'utilité de son existence.

Dr DEWETTEROVA.

UNITED STATES

Note : There is no official report from the National Corresponding Secretary, as one was published recently, but we thought to interest members in printing below some extracts from a paper by Dr Valeria Parker.

There are no habits and customs in the United States which make medical women specially necessary. The presence of medical women has facilitated the creation of new services well received by the population. In reply to the question if the activity of medical women has improved the hygiene of the women and children it is stated « in some instances, especially in public health services. They have perhaps been particularly effective in stimulating social service work in the field of medicine. The work in child hygiene and social service in connection with the V. D. clinics has been largely stimulated by women in the medical and nursing professions ».

Medical women are employed both as workers and as organisers to a very great extent in maternity, infant and child health work. They are employed at the headquarters of the Federal Government at the present time to collect information and to research with respect to conditions relating to maternity, infant and child health. They are frequently employed in Federal and State Departments dealing with health and, in some instances, as country and local health officers. They are also employed in connection with mental hospitals, jails, factories and schools. The first medical woman, Dr Elisabeth Blackwell, began to practise in 1849.

Dr Valeria PARKER.

COMMISSION PERMANENTE D'ETUDE DES CONDITIONS SANITAIRES DES FEMMES ET DES ENFANTS INDIGÈNES DANS LES PAYS EXOTIQUES

Les rapports présentés au Congrès de Vienne sur le travail des femmes-médecins dans les pays exotiques ont fait ressortir si vivement la nécessité et l'urgence de ce travail que le Congrès a été unanime à voter la création d'une Commission permanente pour l'étude des conditions sanitaires des femmes et des enfants dans les pays exotiques.

Nous ne saurions mieux définir la nature et les buts de cette Commission qu'en citant les propres paroles du Dr Margaret Balfour, qui en a préconisé la création et en assumera la direction.

« Ces rapports ont démontré qu'il y a maintenant dans les pays exotiques un grand nombre de femmes-médecins appartenant à différents pays et qu'elles y rencontrent de nombreuses difficultés. Ces difficultés sont dues parfois à l'isolement où elles se trouvent, ou au manque de locaux et de matériel, parfois à l'ignorance et aux préjugés de la population indigène, et aussi à la gravité d'ordre professionnel et aux complications des cas qu'elles peuvent avoir à traiter, avec un personnel insuffisant et inexpérimenté.

« Les femmes-médecins ont souvent à faire, surtout au moment de la grossesse, à des maladies peu connues dans les pays européens et sur lesquelles chacune doit former sa propre expérience.

« La mortalité maternelle et infantile dans ces pays est très élevée, et souvent les enfants se développent mal, faute de soins médicaux préventifs et curatifs suffisants.

« Le Conseil de l'A. I. F. M. espère que la Commission permanente pourra recueillir une documentation qui lui permettra de répondre à des demandes de renseignements et surtout qu'elle attirera l'attention du Conseil sur les cas où une action publique pourrait utilement être poursuivie, en faveur soit des travailleurs médicaux soit des femmes et enfants indigènes.

« Le Conseil espère aussi que la Commission pourra créer un centre où des femmes-médecins des pays exotiques pourront discuter leurs problèmes, de vive voix ou par lettre, et où elles trouveront de nouvelles inspirations concernant leur travail. Il espère, en outre, qu'elle pourra de temps en temps entreprendre des recherches et recueillir des informations de différentes régions, capables de faire la lumière sur certains problèmes des pays exotiques.

« Dès que les Secrétaires Nationales Correspondantes auront communiqué en nombre suffisant les noms des femmes-médecins disposées à servir dans cette Commission, le Conseil élira parmi les personnes proposées les membres de la Commission permanente. »

Pour souligner l'importance du rôle que peuvent remplir les femmes-médecins dans les pays exotiques et montrer quel champ d'action s'ouvre devant notre Commission permanente, nous donnons ici quelques extraits particulièrement suggestifs des rapports envoyés l'an dernier en réponse au questionnaire.

STANDING COMMITTEE OF ENQUIRY INTO THE HEALTH CONDITIONS OF NATIVE WOMEN AND CHILDREN IN EXOTIC COUNTRIES

The reports presented at the Vienna Congress on the work of medical women in exotic countries showed up so strongly the urgent necessity for this work that the Meeting was unanimous in voting the creation of a Standing Committee to study health conditions of native women and children in exotic countries.

We cannot better define the nature and objects of this Committee than by quoting the words of Dr Margaret Balfour, who first suggested its creation and who will be one of the Directors :

« These reports showed that there are now large numbers of medical women, belonging to different countries, who are working in exotic countries and who meet with many difficulties, sometimes owing to their isolation, sometimes owing to lack of buildings and appliances and sometimes owing to the ignorance and prejudices of the people ; also, of course, owing to the severity of the professional complications they meet with and which they sometimes have to treat with insufficient and poorly-trained staff. Disseases are sometimes met with, especially in connection with pregnancy, which are little known in European countries and regarding which each medical woman has to gain her own experience. There is a very high infant and maternal mortality in these countries and in some the children are growing up weakly for want of proper medical prevention and treatment.

« The Council hopes that the Standing Committee will collect information regarding exotic countries and will pass it on to enquirers, and especially that it will draw the attention of the Council

to occasions when some public action could be taken for the benefit, either of the medical workers or of the women and children of the country.

« It also hopes that it will form a meeting house where medical women from exotic countries can discuss their difficulties, either personally or in writing and get fresh inspiration regarding their work.

« It hopes too that the Standing Committee may from time to time take up some piece of research and collect information from different countries which may throw light on some of the exotic problems.

« As soon as the names of sufficient medical women have been received from the National Corresponding Secretaries the Council will proceed to elect from among those the members of the Standing Committee. »

In order to draw attention to the importance of the role that medical women may fill in exotic countries and to point out the wonderful field of action open to our Standing Committee we print below some particularly telling extracts from the reports sent in last year in reply to the questionnaire.

EXTRAIT DE RAPPORTS PARTICULIERS SUR LE TRAVAIL DES FEMMES MÉDECINS DANS LES PAYS EXOTIQUES

EXTRACTS FROM INDIVIDUAL REPORTS ON THE WORK OF MEDICAL WOMEN IN EXOTIC COUNTRIES

ASIE

INDIA

by Dr Ida S. Scudder

The climate of India affects the Westerner in different ways. Some spend their lives here and are never ill, others are never quite well, especially if at the beginning of their stay they are unfortunate enough to contract malaria or dysentery. The climate is enervating and one finds she cannot accomplish as much, nor

keep up the same amount of enthusiasm and energy as at home. The effect of the climate tends to make one more nervous, but one learns to accept it and to conserve strength. In this day of advance in India, when one can have modern comforts and can get away to the mountains during the hottest months, one is able to keep fit and well. There are a few who cannot live in India but they are very few.

The call of the East to medical women has been very insistent and still continues to be great. Anyone listening to the statistics collected by Dr Balfour cannot but feel how appalling is the need for medical workers. When a western woman faces the work in these exotic countries she has to have an additional supply of courage and enthusiasm.

The people among whom she works are frequently hopelessly ignorant of the very first principles of cleanliness, or of the care of the sick. All are conversant with the fact that it has been and is the custom (except in educated and enlightened homes) to put a woman who is in labour in the darkest hole in the house — the less light the better — cobwebs festoon the walls, the room has often been used as a place in which to keep all the things not wanted. Here the only light is from a tiny oil lamp with a wick which needs constant attention ; the attendant, often an old, half blind woman, is the only one allowed. The air in the room is stiflingly hot and close. Introduce a young doctor who has just finished her house-surgeonship in one of the beautiful modern Maternity Hospitals, into such a room, to apply forceps possibly, and it takes a lot of courage and determination to overcome such conditions. In another instance a call may come from a village, and the doctor works to save her patient in a room where there are cattle and poultry crowding about. Again one is called urgently to a home and on entering it finds the babe born. But the floor is flooded with blood, the patient is standing against the wall with one old hag of a « dai » pulling on the cord of the undelivered placenta while a second one is boring into the abdomen with her head (whose hair is far from clean). The patient is having an appalling haemorrage. The repetition of such cases often staggers the young western doctor and she feels how impossible the task ahead of her seems.

Possibly one is called to case after case of sepsis and investigation shows that each case can be traced to the same Dai (native midwife). Where is she ? Would it be possible to talk to her ? No. The families have had her or her grandmother for years, the Dai is alright — the septic fever must be fate. And no matter how hard our young doctor tries to help, her hands are tied. She has only one chance to help. The Dai must be found, she must be trained — an almost impossible task.

The women of India cannot be treated in the same section of

the hospital as the men, and no hospital for women existed in India until the Missionaries and Government established them. It is tremendously worth-while work, and if a crying need makes an appeal to a woman's heart, it will be found in these Eastern countries.

But she must be ready to face many disappointments. Sometimes after working for hours day and night over a patient, giving of her best in skill and strength, and seeing the tide turn and the patient with a chance of recovery, she is aghast when called to the hospital to find a group of relatives with a conveyance at the door determined to remove the patient from the hospital. No amount of arguing will prevail, and the patient, whom the doctor knows she could save, is taken away. In a short time comes the expected word — the patient is dead.

A surgical case is brought in. The doctor visualizes a successful operation and a well patient. But operation is refused ; « give medicine, we cannot allow an operation » is the answer. And the doctor sees a patient taken away who could so easily have been cured. Into one's mind comes the thought « what is the use, they don't want help », but looking back over thirty years of service and experience one sees a vast improvement in the attitude of the people, especially among the educated.

One of the compensations and opportunities of medical work in the East is that a doctor has her own hospital where there is the chance to develop work along the lines she wishes. Complete control of all the work and being chief in the hospital puts the western doctor on her metal. Having to do the most difficult operations and maternity cases and being up against something one never dreamed of having to attempt, having to do work alone and without consultation soon develops whatever gifts she may have. All the responsibility falls on her shoulders. Operations are often undertaken which, at home, would be sent to a specialist. In the East the doctor has to be a specialist in all things and it is often gratifying to see the results that are obtained. There is never any lack of stimulants to the medical interest.

There are many difficulties to be faced in exotic countries. Prejudices and superstitions are always to be considered. Many believe that there are certain dark hours during the day when nothing should be undertaken, no operation or treatment may be done. One case was reported : a young Hindu woman was having a perfectly normal labour, but the superstitious Dai realised that the baby would be born during a dark hour, and in this particular instance that would be disastrous. Knowing this must be prevented, she called in others more ignorant than herself, and after consultation it was decided to suspend the patient by her feet from the rafters. This was done. When the dark hour was over the baby was still unborn, and the mother was so quiet and submissive

that the Dais were congratulating themselves, but on lowering her they found that life was extinct. Was anything done to these meddling women ? No, they simply slipped out of the house and no one found them.

Unlucky days play a large part in ones hospital practise in India. Nothing can persuade a patient to begin treatment on an unlucky day, no matter how urgent the need, and the western doctor often hesitates to over-persuade the friends even though she knows the need of immediate care.

Festivals and feasts are a great source of annoyance. Patients are dragged away from the hospital for the feast, only to return in a far worse condition. Imagine trying to regulate a diabetic under such conditions. Weddings and deaths play so important a part with the vast majority that the patient will insist upon attending. The poor doctor is often exasperated at the unnecessary harm done.

The Nursing problem in an Eastern Hospital is great, and presents numerous aspects. Hospital discipline often seems impossible, cleanliness seems unnecessary to the average patient. Spitting the dirty beetle juice on the walls and floors, wiping filthy hands on the walls and sheets, these walls are just like those in their homes, so why must they be kept clean ? Each patient has at least one relative who stays with her in the Hospital and these people add to the trouble of keeping cleanliness and order. They have not the faintest idea of cleanliness. At almost all treatments the relative is in attendance, and a very dirty hand may be thrust into the sterile douche water just as it is ready to use. Sheets are worn around the patient when she gets out of bed, she walks on the bare floor with her bare feet, but it never occurs to her to wipe her feet before she gets into bed again. The floor is the easiest place to throw rubbish, the veranda floors are stained with the red of the beetle juice. But they have never known anything different so why should we expect them to change at once. But it is one of the greatest satisfactions to see a gradual change coming. After a time the whole hospital begins to conform to the new methods and eventually the homes begin to show the change. One feels that something of the great amount there is to be done is being accomplished.

There is another means of service in India. Not lucrative, but full of interest and profit to the people of the villages, are the Peripatetic Dispensaries. The first one was started in Vellore in 1908. A village 25 miles distant was in great need of medical help, and sent in an appeal. At about the same time a friend in America sent out a Peugeot car. It was in the early days of motor cars, and this one had but one cylinder, therefore its coming was announced even before it was seen, but it was a great aid to the work it had started out to do, since it attracted so much attention. There were many villages along the road to the one 25 miles distant. Medicines, dressings, sterile instruments were put into the car, and a doctor

and a nurse started forth. At first the people were afraid but at one stop where there were many children with a purulent ophthalmid, which is so prevalent in India and is the cause of so much blindness, one child was presuaded to have a drop of medicine in its eye, although all the others refused. The car went on its way, but when returning that night there was literally a holdup. Children with their parents blocked the road. On getting out to inquire the reason of this, we were told that the child whose eyes had been treated that morning was so much better that all the other children of the village had been brought for treatment. We counted twenty seven patients. Our way was won in that village. The next week poeple were waiting in large numbers, some who were too ill to walk were brought on stretchers, and we found many interesting medical and surgical cases there.

Since that time roadside work has increased tremenduously. In four other directions have roads been opened and, weekly, one hundred and eleven miles of road are covered by ambulance sent out from the Vellore Missionary Medical School. People come to the roads to await the weekly visit of the ambulance. They come from distances of fifteen to twenty miles by foot or in two-wheeled carts drawn by a diminutive bullock, or the very ill are brought on stretchers. Some come the night before and camp under the trees near the road to await the ambulance which arrives early in the morning. Many of these people expect an immediate cure but many come week after week to the doctor.

An enormous amount of good is being done in this way in clearing up diseases of eyes and ears and in finding the chronically sick and those having tumors which their people do not treat and in bringing them into the hospital for treatment. The usual numbers seen on these roadsides in one day vary from 150 to 250 but on one road, where there are a great many lepers, as many as 566 have been seen in one day. Not only is this type of work done but health talks are given, and attempts to teach hygiene are being made on these roads. As I have said before the wor kis not lucrative. If we succeed in getting two pence for a treatment and a week's medicine we feel that we have received quite a fee.

The lepers are flocking to these roads. The new method of treatment, giving hope to these formerly hopeless sufferers is bringing them to us in ever increasing numbers.

The Western woman's greatest service to the Exotic Countries is that of raising standards and of training the young women for Medical work.

Only a few years ago, the Nursing profession was looked upon as an inferior occupation. The nurse was expected to do the dirtiest work, and no respect was given to her. That day has passed. The Indian girl is coming into her own. Formerly education was considered an unnecessary qualification for a nurse. At present

High School Finals girls are comprising the nursing classes in a few hospitals and as soon as the Government does away with the « L. M. P. » — Licensed Medical Practitioner — grade of Medical Training, many more of this class of girls will join the nursing classes. This profession in the Eastern Countries is gradually being looked upon as a worthy one.

Well trained Indian Medical Women are filling many important posts at present. Knowing their own poeple as a Western Doctor never can, and understanding the customs and superstitions of their country makes them better able to cope with their own people.

It is the desire on the part of many to raise the Medical Standard among the Women of India. At present the L. M. P. is the lower standard. This course requires only a High School training before entrance into Medical School. Students with no higher a qualification than this are necessarily underdeveloped, and it is difficult with so poor a background to train a good doctor. Nevertheless many who have taken the L. M. P. are doing excellent work, and are making fine doctors.

The Indian girl responds to the Westerner's help in education in the most remarkable way. Les us therefore give her of our best so that she may undertake, in the future, the medical work of which India has such great need.

by Dr Dagmar Curjel-Wilson.

Rickets. — No race in northern India is immune, but rickets in its various forms, infantile rickets, late rickets, osteomalacia are much more prevalent in certain castes owing to their mode of life. The disease is rare among men and boys except in conditions of extreme deficiency of diet or sunlight, but is chiefly met with among girls and women during adolesence and in connection with maternity. Rickets and osteomalacia are found in northern India and Kashmir in towns wherever there is deficient sunlight combined with an unbalanced dietary, and in rural areas whenever plentiful sunlight cannot compensate for a diet quantatively and qualitively deficient. The examination of over 1500 cases shows there is no caste or race distinction, a large number of urban cases occur among women and girls in fairly good social circumstances, and familial incidence is often present.

The incidence of rickets was high in over-crowded and walled cities and in towns with narrow lanes and high sunless houses, as in Delhi and Gujranwala, or in densely populated bazaars, such as Simla, among Hindu and among purdah observing Mohammedan girls and women.

As the result of the examination of over 2000 children of

school age, rickets in towns was found to be associated with lack of sunlight either in over-crowded schools, or with diet also in certain industrial areas.

by Dr J. Jhirad

Most medical women in India confine their practice to women and children only, and they are in great demand for such work, as even apart from the purdah system which prevails in some parts of India, women prefer to go to their own sex for their special ailments.

by Dr Ruth Young.

The improvement of hygiene is a self-evident fact. Adequate proof is not easy to supply, but infant mortality decreases where there are proper child welfare schemes, e. g. in Madras the infant mortality rate for the whole city was 256.6 while that of children under the care of the Child Welfare scheme was 171.6 (1929).

DUTCH EAST INDIES

by Dr N. Stokvis-Cohen Stuart.

Maternity. — The great majority of native women are attended in child-birth by untrained, old, native women, the so-called Dukuns, owing to the fact that there are few doctors in proportion to the population, who, moreover, cannot afford to pay them. Besides, the great, great majority of natives either would not dare to call in Western help, or do not like to, or do not trust such help. They are still very ignorant and uneducated, about 90 % of them being illiterate.

In many cases malaria is the cause of disease during pregnancy, and very often pregnancy ends in abortion or premature birth. Very often, too, we meet with beri-beri (avitaminosis) as a cause of disease during pregnancy, and in the puerperium ; it may often cause the death of the child in the early months of its life. In serious cases the mother may die during her confinement owing to weakness of the heart. Eclampsia does not occur so very often. Syphilis too may cause still-birth, but here it is not one of the most frequent causes.

A frequent cause of death among infants is the belief, prevalent among the natives, that it is not allowed to cut the cord before the placenta has been expulsed. As this expulsion is often many hours, or even days, late, as the dukuns do not know how to bring about delivery of the placenta, the baby is left lying between the mother's legs, where it may die without being taken away. Then the mother may die too, from infection and lack of proper care.

There is no great difference between the diseases in pregnancy found in Europe and those found in the East Indies, with the exception of beri-beri. The natives live mainly upon rice and are often therefore deficient in vitamines, and many native women are affected by the disease in pregnancy, as are many breast-fed children also.

The religion of the natives does not forbid native women from being treated by male doctors, but I know from my own experience that it is much easier for a medical woman to be admitted than it is for a medical man. When a native woman is in labour and in danger, she will not object to a man's help, but if she is pregnant and not in any danger she will hardly ever consent to go to a male doctor to be examined. Also in many cases of illness she will sooner go to a medical woman than to a man, so that it is very necessary that medical women should devote themselves to work among the natives.

I was the first medical woman who practised among the natives, and I came to Java in 1908. There are more medical women now and a few years ago the first native medical woman passed her examination. I am convinced that the activity of medical women has improved the hygiene of the native woman and her child, and that good results are obtained through their teaching of native girls.

INDO-CHINE

Extrait d'un rapport du Dr M. L. Blot

Le *beri-beri* est, au Tonkin, une maladie presque toujours liée, chez la femme, à l'accouchement, cette maladie se déclarant presque toujours après l'accouchement, même normal ou le paraissant.

Les complications graves de l'accouchement anormal, telles que fistules vésico-vaginales par exemple, sont beaucoup plus fréquentes qu'en Europe à cause du nombre d'accouchements compliqués effectués par des personnes inexpérimentées.

Les Annamites ont, par nature, peu confiance dans les femmes, et peu de confiance en des femmes-médecins ; cependant les femmes annamites n'aiment pas beaucoup se montrer à des hommes ayant parfois encore assez peur de l'Européen. Il y aurait tout avantage à ce que les femmes soient chargées de tous les services de femmes et d'enfants, toute la question de maternité dominant la médecine en Indo-Chine, car les femmes ont un nombre d'enfants extrêmement élevé et la stérilité est considérée comme « une punition des génies » et une honte pour une famille.

PERSIA

by Dr Stella Henriquez

Conditions are very different from those in England. The patients are extremely ignorant as a rule, very rarely does one come across a woman of thirty who can read and write.

The custom is to call in as many doctors as possible to a case. It is not at all uncommon to be called to see a patient after four or five doctors have been in attendance. Patients attach no shame to such behaviour and will glibly recite the names and treatments of the previous doctors. In such circumstances one often finds it difficult to take a real interest in a case since one knows that if, after one or two doses of medicine (possibly a bottle might be finished), they are not very much better, they will go on to somebody else.

In a Moslem country like Persia, men are not allowed to see a woman's face if she is not of their own family. This means that any examination which is needed very seldom takes place, and I am continually in request by doctors to examine chests. I then report to the doctor the condition of the heart and lungs and he continues to treat the lady in question. No man can do a gynaecological examination, so I get a good number of cases of that description. Many of them are for sterility, the situation being that if no child is forthcoming, the woman will be divorced or a second wife will be taken. The people are ruled by superstition. They will not come into hospital on a certain day because it is unlucky. They will not have an operation if the omens are against it.

A woman with a septic breast, pouring with pus and needing more attention than can be given by a daily dressing in the outpatient department, may not be able to come into hospital because her husband will not permit it. This, regardless of the fact that she is running a temperature, is thoroughly septic and is almost too weak to walk. She must work till she drops, and if she drops dead it really does not matter much, he can get a fresh wife.

Of course there are exceptions, but the majority of the Moslems I have met, look upon their women as fit for nothing but the procreation of children (and they must be sons, no one wants a girl baby), and the ministering to their husband's needs. This is the outcome of marriage between a man of eighteen and more and a child of nine, between two people who have never seen each other until their marriage night.

Though the marriage ceremony takes place in many cases when the girl is nine years old, and the girl lives in her husband's house, as a rule sexual connection does not follow until after the first menstrual period.

It is a mistake to think that Persian girls mature early. The

twelve year old child is often a little, undeveloped creature. She has left school at nine and is consequently very ignorant. She leads a very sedentary life, does not know how to play games, and it is this kind of child who is brought into hospital, her perineum ripped to her anus following her first sexual connection with her husband. She may be literally demented with the shock. These cases are not rare.

Among the Zoroastrians this is not common, the girls are married much later, and so also are the girls belonging to the religion known as Bahaism.

Ignorance is also the cause of many intranatal complications. One case of delayed labour was in the case of a woman who could have delivered herself if the first essentials of hygiene had been observed. But her bowels had not moved for five days, her bladder had not been emptied for 24 hours. Uterine inertia followed. About an hour after delivery by forceps she died, from pure exhaustion.

Regarding infant mortality, ignorance again. Midwives know about artificial respiration. If a child is born in an asphyxiated condition the midwife decides it is dead and leaves it alone, in which case it usually dies. It is always a matter for surprise among the patients' friends that we take the trouble to work over a child which is apparently dead. If it revives we are looked upon as miracle workers.

Again, puerperal sepsis is so rife that the women think that something has gone wrong if they do not get fever following a confinement. The native midwives of course are at the root of it all, filthy and ignorant. Syphilis also accounts for a large infant mortality.

I consider that the presence of women doctors in this country has undoubtedly saved the lives of numbers of women and children, and by all thinking Persians this is generally acknowledged and appreciated.

CHINA

HONG-KONG

by Dr Ariel McElney.

Diseases in Pregnancy — Aneamia is very common, owing to extreme debility which occurs among many of the women. The debility is in most cases simply due to under-nourishment owing to poverty.

The S. P. C. C. give in their last report an item which illustrates this poverty — « the aggregate monthly incomes of 88 families, comprising in all 340 individuals, amounted to S 1.301,40. In other words, there was an average income of slightly over S 3.80 (3/8d) per head per month, out of which to provide food, lodging and clothing ».

Oedema of a very bad variety occurs very frequently, often unassociated with albuminuria. It is probably due in most cases to the women working all day on their feet, carrying heavy loads, mending roads and in building operations.

Diseases in women — Tuberculosis is very common indeed. Its spread is occasioned by the confined quarters in which they live ; on land several families in one room, divided by cubicals, and on the water crowded together in their small sampans.

KOREA

by Dr Davies.

The activity of medical women is advisable from age long habits and customs derived from the former seclusion of women.

The teaching of science in the highest girls' schools is not enough to enable women to compete with men in the entrance examinations in the established medical colleges, even if these were open to women, which they are not. The Women's Medical College in Tokyo is full to over-flowing. In Korea there is a Missionary Medical Institute for women and some of the women trained there go on to the Women's Medical College at Tokyo, while others, having gained the Institute diploma, remain and work locally. It is hoped, if funds can be raised, to develope the Institute into a Medical College.

One or two women have been appointed to Government Hospitals. They have not much opportunity of controlling their work nor, as yet, are they appointed to the higher posts.

As regards conditions of child-birth many untrained midwives practise, although many have been trained. A frequent cause of difficulty in delivery is atresia of the cervix and vagina. Prolapse of the uterus is common after delivery, due to the women getting up immediately. Ir is treated by burning or by the application of strong caustics. The result is, not infrequently, rupture of the uterus at the next child-birth, with death of mother and child, or, if she reaches hospital in time, delivery by Caesarian section.

AFRIQUE

KENYA COLONY

by Dr M. M. Shaw.

Speaking of intra-natal complications, the first point which will probably occur to the mind here is unfortunately the question of female circumcision. I say, unfortunately because, in my opinion, it has been already over-discussed and probably over-esti-

mated as a factor in maternal and neo-natal deaths. A more detailed explanation may therefore be advisable.

In the first place the practice, which in essentials consists of a cliteridectomy, but which is often accompanied by removal of part of the labia minora or even labia majora, results in a hard cicatrice surrounding the vaginal orifice. The practice is not limited to the tribe known as Kikuju but finds a place in initiation ceremonies of Masai, Nandi and Nubian (the worst case I have seen was a Nubian woman).

To our views, of course, it is a stupid and mutilating custom, but to them it is an integral part of their tribal laws and tribal laws may be regarded as we regard the practices of whatever religion we may profess to hold. Circumcision of females to them is as important as ritual circumcision of the male to the orthodox Jew. Any attempt to prohibit such a practice by law or by force would make the fanatic more fanatical, whereas education would probably, after two or three generations, lead to its abandonment.

Apart from this, any difficult cases of labour I have seen were emphatically not a result of circumcision and the last I had in a Kikuyu woman was a case of contracted outlet and a persistent posterior presentation. This woman was six days in labour before being brought to hospital for admission.

My own view is that careful pelvic measurements, foetal skull measurements and the effect of diet and of weight-carrying on the growth of bones will give us far more accurate and scientific reasons for the majority of complicated labour cases in native women. I am not seeking to minimise the evil effects of circumcision but I do feel the tendency has been to attribute to it much for which it is not responsible.

The great difficulty in any medical work in this country is the uncivilised and raw state of the native — his ignorance makes him inclined to be suspicious and although he has a great respect for European medicine, any striking progression must await a universal desire for education. My own work, which I consider truly should be only half medical and half teaching, bears this out. There is at present little foundation on which to build a knowledge of the most elementary facts of cleanliness and hygiene and I am being quite honest when I say a large number of my patients come to ante-natal and child-welfare clinics because they know, or trust, or like me or the particular nursing-sister in charge. However, to come in that spirit, is to come in a receptive frame of mind, and one is heartened occasionally by surprising responses.

The second great difficulty is the language. You will see in many books that Kiswahili is the « lingua franca » of the whole of the east coast of Africa to Zanzibar and beyond. It has a wonderful vocabulary and is a beautiful language, but it has its limitations and here in Nairobi where there are representatives of many tribes

one wishes for the Pentecostal fires to descend on one, for an intimate knowledge of natives is a practical impossibility without a knowledge of their language.

Summarizing the whole situation, these are early days for the employment of medical women in this Colony and the vast mass of native inhabitants have, as yet, not assimilated the value of curative medicine which must precede an appreciation of preventive medicine. I am certain Government is fully cognisant of the need for education and instruction of native women, and I am equally certain that at present enthusiasm should be accompanied by very detailed consideration of existing circumstances and by a true knowledge of native needs and capabilities in the future.

NYASALAND

by Dr Elizabeth McCurrach.

Nyasaland, in British Central Africa, where I have worked, is a little country with an area of 40.000 square miles and a population of one and a quarter million natives of the Bantu group, sixteen hundred Europeans and fourteen hundred Asiatics. The largest European settlements, 4 in number, have a population consisting of Government officials, traders and the planters from the surrounding estates.

The only places where women are employed are in the mission hospitals, where natives of both sexes are received. Where women doctors are in charge of these hospitals, they have to undertake all kinds of work, medical, surgical and maternity work. Besides this there is a considerable amount of work outside among European and Indian women. In outside practice women have no special difficulties, as many women are keener to have a woman doctor than a man.

Maternal mortality is very high as can be seen from the number of cases that come to hospital in the late stages of labour. Unskilled attendance at child-birth is the most important of all causes of this. The woman is separated from her family and put into a hut with the filthiest of rags for clothing and nothing that has any claim to cleanliness is allowed to touch her. Soap and water are unknown quantities. Then she is given no food from the beginning of labour until delivery, with the result that a prolonged labour results in the woman being doubly exhausted. Naturally this causes much maternal mortality, which would be higher still were it not for the saving qualification that they make no vaginal examinations. Any old rag is used to wrap the new born baby in, often with resulting tetanus and septicaemia.

When inertia occurs, nothing is done and the woman is then the victim of the consequence of pressure of the head on the parts

of the vagina. Many a time one can tear away the labia like a piece of tissue paper ; intra-vaginally the results are appalling. If death does not occur from septic absorption, and the vagina heals, there is either the most distressing vesico-vaginal fistula or such contraction that the birth of another child is impossible.

Education is advancing now to such an extent that, if there were organisations for training workers, it would greatly improve the maternal mortality.

Native women would never accept treatment from a man, were a woman available, as all their manner of life and their natural reticence leads to this preference. Then the increased number of Indian women in the community also calls for women.

Before the advent of medical women the percentage of women who allowed themselves to be treated by men was very small, most preferred to be without any treatment at all, and would not go near the hospitals. Now that is gradually changing.

The women who work in Nyasaland find that their work increases very quickly and more and more women are coming to be treated, especially in venereal disease and in maternity. There is every evidence too, that these poor women are beginning to apply the knowledge that is being taught them and we look forward to a much reduced maternity and infant-mortality deathrate.

Women doctors are badly needed and would find the work congenial. It is not advisable to go prospecting, but an appointment in a hospital will bring much happiness and great benefit to thousands.

SUDAN

OMDURMAN

by Dr Elfrida Whidhorne.

It must be remembered that the Sudan spreads over an area between latitude 21° to the Equator, and between longitude 21° to 24° i. e. 1.008.100 square miles.

The Northern provinces are entirely Moslem, and it is to these that I refer my remarks.

The Woman of the Northern Sudan is a lady of large dimensions, whose ambitions in life are to be fat and bear children. She begins life as an adorable brown baby and becomes a slim and attractive graceful small girl with beautiful manners. At the age of 10 her nerves are first undermined by the horrible custom of circumcision, and the tribal marks are cut on her face with a razor. A short time later she becomes hareem and is a prisoner within the four walls of the mud compound. She is now being fattened and prepared for marriage, which with luck, takes place at fifteen or sixteen. (The marriage and the funeral are the chief interests of feminine society in Omdurman). From twenty to thirty she is

so busy bringing children into the world that she does not have time to look after those already belonging to her. Soon after thirty she becomes a grandmother and as such she takes over the charge of her daughter's children, whom she looks after well according to her lights. These lights, in most cases, consist of allowing them to feed on dates, native bread etc, and if convenient to suck from her own breast. When remonstrated with she says « what can you expect, we are only cattle ».

Not only is there an appalling waste of infant life and health as a result, but also there is an equally appalling waste of womanhood.

The Work and Usefulness of Medical Women. — There is a large scope for women doctors in this country, but the climate is such that only the strongest can stand it for any length of time, and the great matrimonial opportunities furnish further difficulties. The question of language and the suspicions of the people require a great deal of preliminary spade work, before any satisfactory steps can be taken. Housing is another difficulty.

Maternity Work. — Maternity work has been well tackled by the midwives ; but there is great scope for women doctors attached to any hospital. In many cases the trained midwives go out from the training school into the districts where there is very little assistance within reach, and they have to combat single handed all the prejudices and superstitions of their own people.

The circumcision of women is an evil which complicates all midwifery work. The problem has not been tackled yet and is universal. It is thought by those who know the people well, that a change will only come through the education of both sexes.

Infant Welfare Work. — Infant welfare work here, even more than in other countries, requires infinite patience and much uphill work. In the absence of clocks and calendars, each mother has to receive a personal invitation before each clinic. The chief characteristics of the Sudanese woman are laziness and indifference and their minds are entirely untrained to any form of regularity or effort. Last winter, with the help of a trained sister, I attempted a welfare clinic once a week ; very little was accomplished. Out of 26 children only seven could be persuaded to attend regularly — these were all the children of three mothers, the wives of educated effendis.

As I have said before there is magnificent potentiality in these women, good nature, affection, loyalty, etc. The educated man is calling out for an educated woman to be his wife. It is the woman who is holding back the progress of the country.

The Hareem Customs. — The hareem customs among the Moslem population make a woman doctor necessary for all women's work. The women will sometimes submit readily to an examination by a very sympathetic British doctor, but there is still much prejudice to be overcome. Most gynaecological work is carried on in the dark. This is all the more unfortunate, as the mind of the young married woman seems to centre in her pelvis, and ignorance of what is actually occurring inside her, gives place to wild speculations, which prevent her from raising her thoughts outside herself.

Women doctors can visit the hareem quarters and therefore can see cases which would not otherwise come to hospital.

Wherever possible the women and children have been very ably looked after by the Government doctors, but there are still vast tracts untouched by any medical work.

The first woman doctor practised here in 1926.

EGYPT

CAIRO

By Dr C. A. Stuart.

Some of the rich women in Egypt are attended by doctors in childbirth. Most of the poor women are attended by untrained women. They prefer this, rather than having trained women from the welfare centres, because of ignorance, superstition etc. They all prefer to be confined in their own houses, rather than in institutions.

Unskilled attention is a very large factor in causing maternal mortality, still-birth and infant death. This state of things is due to ignorance of the need for care on the part of the people. It has, in the past, been also due to lack of personnel and organisations for the training of workers, but this is rapidly improving.

Up to the present medical women have met with no opposition on the part of the male members of the profession, probably because they have been so few in numbers and have not been candidates for appointments, etc.

The majority of women, both Moslems and Christians, dislike going to men doctors. The majority of men dislike having their women attended by men, especially for gynaecological ailments. Before the arrival of medical women, women and children were looked after by men doctors or by « Sally Gamps ».

Medical women are especially necessary for welfare work, with its antenatal clinics. One sees how the women attending our welfare centre improve, and how the children improve in cleanliness etc. Women are learning to come to doctor and to bring baby to doctor when ill, rather than go to « Sally Gamps » or try their own remedies first. This is a great triumph.

Extrait d'un rapport du Dr Gerda Thamsen

Jusqu'à ce moment toutes les femmes-médecins exerçant en Egypte sont de nationalité étrangère, ce qui leur donne une situation toute particulière qui va plutôt en s'accentuant à cause du nationalisme ardent.

La présence des femmes-médecins est très utile, surtout pour la population rurale, où les femmes ont encore, quelquefois, peur du médecin homme. En ville la situation est pareille à celle de l'Europe.

On ne peut pas dire que les maternités, dispensaires, etc., ont été créés grâce à la présence de femme-médecins ; c'est le développement général du pays qui les a fait naître et alors on a dû faire appel à des femmes-médecins étrangères. Je crois que la présence de femmes-médecins indigènes ferait beaucoup de bien, car elles auraient peut-être plus d'influence sur les femmes ignorantes et arriveraient à combattre les vieilles habitudes malpropres et funestes.

TUNISIE

Extrait d'un rapport du Dr M. Nicolle.

Les conditions de travail des femmes-médecins sont plus difficiles ici qu'en France, mais ces conditions sont les mêmes que pour leurs confrères hommes. Ce sont des difficultés d'ordre climatérique (l'été est en Tunisie pénible pour l'Européen qui travaille) et d'ordre linguistique : le médecin, surtout dans les hôpitaux indigènes ou dans les dispensaires, doit faire un effort plus grand pour s'exprimer dans une langue qui n'est pas la sienne ; et finalement des difficultés d'ordre social : surtout dans les hôpitaux et les dispensaires une foule beaucoup plus considérable qu'en France s'adresse au médecin, foule dont les éléments sont généralement affreusement sales et parasités, ignorants de tout, à tel point qu'il est souvent difficile de les traiter convenablement. Quand il s'agit de femmes, la question est encore plus grave.

Cependant, et heureusement, grâce à la création d'écoles de plus en plus nombreuses, les Arabes évoluent et la tâche du médecin devient plus facile, son effort plus profitable.

La mortalité maternelle a pour causes principales la syphilis et l'accouchement négligé, si fréquent dans les campagnes. L'ignorance, le laisser-aller et le fatalisme des Arabes, le peu de soucis qu'ils ont généralement pour leurs femmes quand il s'agit de nomades en sont d'autres causes extrêmement fréquentes.

Les causes de la mortalité infantile sont, avant tout, la misère physiologique et l'ignorance des mères. Les enfants, sous-alimentés ou nourris de manière souvent incroyable, meurent fréquemment de troubles digestifs, de tuberculose ou de broncho-pneumonie.

Les mœurs et coutumes de la population tunisienne rendent extrêmement utile l'activité des femmes-médecins.

En clientèle il existe, surtout en dehors de Tunis, bien des familles arabes où le mari hésite à faire examiner sa ou ses femmes par un homme. Donc, plus il y aura de femmes-médecins, mieux les femmes indigènes seront soignées.

Au point de vue de l'hygiène sociale, nous pouvons approcher, en tant que femmes, plus que nos confrères, de l'élément féminin, dans les hôpitaux, dispensaires et écoles et ainsi gagner très facilement la confiance des femmes ; par les jeunes nous agissons plus efficacement sur leur instruction hygiénique et par là les aidons à évoluer, à s'élever. Puis les femmes arabes, ainsi instruites, auront bientôt une influence sur leur mari, qu'elles garderont davantage à leur foyer ; nous arriverons ainsi à contribuer au progrès de la famille entière.

DIVERS

LA GUADELOUPE

Extrait d'un rapport du Dr Marie Michel

Les maladies causées par la grossesse ou associées à la grossesse sont les mêmes qu'en France. Leur fréquence est moindre, en raison du faible pourcentage des grossesses associées à la tuberculose, cette affection étant plus rare ici qu'en Europe.

Enfance. — Le taux de la mortalité infantile est assez élevé : un tiers environ. Une enquête a été entreprise afin de faire connaître les causes de la fréquence des décès chez les nouveaux-nés. Elle n'a point donné de résultats en raison du grand nombre d'enfants décédés sans que le médecin ait été appelé (dans les campagnes).

Il existe, dans tous les centres, pour les enfants comme pour les adultes, des consultations gratuites, très suivies dans les villes et dans les bourgs de quelque importance, peu fréquentées dans les campagnes où l'éducation du public est à faire.

Les questions concernant l'organisation et l'application de l'hygiène infantile étant confiées aux médecins de l'Assistance Publique, les femmes-médecins peuvent y travailler dans les mêmes conditions que les hommes, puisqu'elles peuvent être médecins de l'Assistance Publique.

Ce qu'il faudrait obtenir à la Guadeloupe, c'est plus d'hygiène dans les campagnes et il s'agirait de faire l'éducation populaire, chose très difficile et très lente à obtenir.

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Publication de l'Union Internationale contre le Péril vénérien, 4, rue de Sèvres, Paris.

CONGRÈS INTERNATIONAL DE LA LITHIASE BILIAIRE

VICHY - 19-22 Septembre 1932

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Trois questions sont à l'ordre du jour du Congrès :

1° Les séquelles de la cholécystectomie.

2° Le traitement médical et hydrominéral du cholécyste dans la Lithiase biliaire.

3° Le Foie lithiasique.

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Sont admis comme membres titulaires du Congrès les médecins français et étrangers.

Les médecins désireux de participer au Congrès sont priés d'adresser au Secrétariat la somme de 50 francs français, montant des frais d'inscription et donnant droit aux publications du Congrès.

Toutes les demandes de renseignements, adhésions, cotisations, doivent être adressées au Dr J. Aimard, Secrétaire Général du Congrès International de la Lithiase Biliaire, 24, boulevard des Capucines, Paris (9e).

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